

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

★ Reg. Dist. No. 351

1. PLACE OF DEATH
 County Worcester
 City or town Shidley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Shidley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war 70

3. (a) FULL NAME
Richard P. Burdun

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lillie Burdun
 6. (c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) September 26 - 1875

8. AGE: Years 69 Months 11 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Monticello, New Jersey
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name Isiah R. Burdun

13. Birthplace New Jersey

14. Maiden name Anna F. Jacobus

15. Birthplace New Jersey

16. Informant Mrs. Garland Galy

Address Shidley, MD

17. Burial Date thereof Sept. 16/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Shidley, MD

18. Funeral director Hearnes + Darnis

Address Spring Hill, MD

19. 9/15/45 19 45 Re. Dey Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 19 45, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 45 to Sept. 14 19 45

and that I last saw him alive on Sept. 14 19 45

Immediate cause of death _____

Cerebral thrombosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Aniopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Voss M. D. or other Physician

Address Shidley, Md. Date signed 9/15/45

RECEIVED
SEP 20 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

CERTIFICATE OF DEATH

09418

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
 City or town Berlin P. T. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Annice May Chesser.

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Warren R. Chesser.
 8. (c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) July 6, 1897.
 8. AGE: Years 48 Months 2 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Whitesville Md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business

12. Name Elizabeth Foster
 13. Birthplace Maryland
 14. Maiden name Annice West
 15. Birthplace Maryland

16. Informant Mr. Warren Foster
 Address Berlin Md. P. T. D.

17. Burial Date thereof 9/28/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory One Cemetery
 Location near Pottsville Md

18. Funeral director Anna A. Bynhouse
 Address Berlin Md

19. 9-28 45 Helen F. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1945 at 7:20 P. M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 25 1945 to Sept. 25 1945
 and that I last saw him alive on Sept. 24 1945

Immediate cause of death myocarditis (chronic) DURATION 1 yr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank R. Lewis M.D. M. D. or other _____

Address Willards Md Date signed 9-25-45

CERTIFICATE OF DEATH

RECEIVED
OCT 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH



Reg. Diat. No. 09419 350

1. PLACE OF DEATH

County WorcesterCity or town Pocomoke city md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. Second

(If rural, give LOCATION)

2(a) If veteran, name war: ☒

3. (a) FULL NAME

Margaret E. Clarke

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife: ☒7. Birth date of deceased (mo., day, yr.) August 29, 1868 6. (c) If alive, give age ✓ years8. AGE: Years 77 Months 1 Days 6 If less than one day hrs. min.9. Birthplace Pocomoke, Worcester, md.
(Town, county, and state)10. Usual occupation Kept own home

11. Industry or business

12. Name William J. S. Clarke13. Birthplace md14. Maiden name Elizabeth Hargis15. Birthplace md16. Informant Harry ClarkeAddress Pocomoke city, md.17. Burial Date thereof Sept. 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PresbyterianLocation Pocomoke city, md.18. Funeral director Margaret H. HargisAddress Pocomoke city, md.19. Sept 29, 1945 Adne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26th, 1945 10:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9th, 1944 to 9/26/1945and that I last saw him/her alive on September 26th, 1945Immediate cause of death Results of Cerebral hemorrhage. (Recurrent) DURATION 7 DaysPrimary attack 10/9/44
Due to Arteriosclerosis. Years ✓

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.:

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Lee Hall M. D. or otherAddress Pocomoke City, Md. Date signed 9/28/45

RECEIVED
OCT 1 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town near Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town near Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Harry F. Coffin

3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married8.(b) Name of husband or wife Maggie Coffin8.(c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) Aug 18 18868. AGE: Years 59 Months 0 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Berlin
(Town, county, and state)10. Usual occupation Fish11. Industry or business Fish12. Name Elisha E. Coffin13. Birthplace Berlin, Md14. Maiden name Betty Ann Jarvis15. Birthplace Berlin16. Informant Minnie A. CoffinAddress Bethany Beach Del.17. Burial Burial Date thereof Sept 11 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory N.O.C.F.Location Bishopville, Md.18. Funeral director M. Paul WatsonAddress Silksville, Md19. 9-11- 45 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945, at 12:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

broken neck due to being hit by auto

DURATION

5 min

Due to _____

One to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Sept 9 1945Where did injury occur? Berlin Worcester Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway 213Means of injury Struck by auto Injured at work? No23. SIGNATURE John L. Ray D.O. and ExamAddress Brownlee Rd. M. D. or other _____Date signed 9/9/45

DEPARTMENT OF HEALTH

UNITED STATES GOVERNMENT

PHYSICIAN'S CERTIFICATE

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN

AND IS NOT TO BE USED FOR ANY OTHER PURPOSE

IT IS TO BE FILED IN THE RECORDS OF THE PATIENT

AND IS NOT TO BE USED FOR ANY OTHER PURPOSE

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RECEIVED

SEP 15 1945

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09421

Reg. Dist. No.

355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella Amanda Dennis

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow6. (b) Name of husband or wife George Washington Dennis7. Birth date of deceased (mo., day, yr.) October 27, 18908. AGE: Years 54 Months 10 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles Edward Davis13. Birthplace Maryland14. Maiden name Mahabey Pennell15. Birthplace Maryland16. Informant Mr. Raymond DennisAddress Ocean City Md. R. 1 D.17. Burial Date thereof 9/13/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GreenbushvilleLocation Greenbushville Va.18. Funeral director Dennis R. BurbageAddress Berlin Md.19. 9-19- 45 Robert F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 - 1945 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ and that I last saw him alive on Sept 11 - 1945

Immediate cause of death

DURATION

Coronary

Due to

Cholera

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accidental, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas. R. Law

M. D. or other

Address Berlin Md. Date signed 9-12-45

RECEIVED

SEP 15 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Maggie Lena Godfrey

3. (b) Social Security Number

4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife John Henry Godfrey

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 11, 18718. AGE: Years 74 Months 6 Days 0 If less than one day _____ hrs. _____ min.9. Birthplace Accomack County, VA

(Town, county, and state)

10. Usual occupation Domestic11. Industry or business Home12. Name Abner Bloxom13. Birthplace Acco. Co. VA14. Maiden name Palma Mason15. Birthplace Acco. Co. VA16. Informant John Henry GodfreyAddress Pocomoke City, Maryland17. Burial Date thereof Sept. 13, 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory MetomskingLocation Metomsking, VA18. Funeral director Edgar ThomasAddress Accomack VA19. Sept. 11, 1945 Anne E. White

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1945 at 10:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1945 to Sept 7th 1945and that I last saw Sept 7th 1945 alive on Sept 7th 1945Immediate cause of death Cancer of stomach

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations Refused operation

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

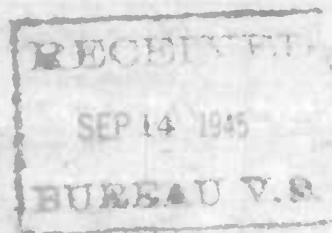
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE N. E. Eastman MD M. D. or other _____Address Pocomoke City, Md Date signed 9/11/45



Miss Annie Whit
Regidor

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (101)

CERTIFICATE OF DEATH



Reg. Dist. No. 350

09423

1. PLACE OF DEATH:

County... Worcester
 City or town... Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years.Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WorcesterCity or town... Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)Street No. —
 (If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

Sarah Holland

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife —

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age — years

8. AGE:

Years

Months

Days

If less than one day

40

hrs. min.

9. Birthplace

Pocomoke, Worcester, Md.
 (Town, county, and state)

10. Usual occupation

General house work

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

45

Anne E. White

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 13, 1945, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Sept 3rd, 1945, to Sept 13th, 1945and that I last saw him alive on Sept 12th, 1945

Immediate cause of death

DURATION

Pneumonia 2 weeks

Due to

Due to

Other conditions

Acute Suffering
Lymphadenitis
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 9/14/45

RECEIVED
SEP 24 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 35

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke city Rural AL
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 72 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Pocomoke city
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Florence Alberta Lamberton

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Harrison Lamberton

7. Birth date of

deceased (mo., day, yr.) October 4, 1872

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

721029

hrs.

min.

9. Birthplace

Stockton Worcester, Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Charles Peter Ardis

13. Birthplace

N. J.

MOTHER

14. Maiden name

Harriet W. Boumeille

15. Birthplace

Md.

16. Informant

Clayton F. Lamberton

Address

Pocomoke city, Md.

17.

Burial

Date thereof

Sept 5, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hall's Hill

Location

Pocomoke city, Md.

18. Funeral director

Margaret H. Watson

Address

Pocomoke city, Md.

19.

Sept. 5, 1945Adne E. White

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 3, 1945, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 23, 1945 to Sept 3, 1945and that I last saw him Sept 3 alive on Sept 3, 1945

Immediate cause of death

Heart Failure

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
SEP 7 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH: *Worcester*
 County.....
 City or town.....*Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*30 years*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland*..... County.....*Worcester*
 City or town.....*Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....*70*

3. (a) FULL NAME
Elliot W. Marshall

3. (b) Social Security Number
None

4. Sex.....*Male*
 5. Color or race.....*White*
 6.(a) Single, married, widowed, or divorced.....*Married*
 6.(b) Name of husband or wife.....*Anna Louise Marshall*
 6.(c) If alive, give age.....*51* years
 7. Birth date of deceased (mo., day, yr.).....*April 19 - 1890*

8. AGE: Years.....*55* Months.....*5* Days.....*8*
 If less than one day..... hrs. min.

9. Birthplace.....*Allemae, Virginia*
 (Town, county, and state)

10. Usual occupation.....*U.S. Post Master*

11. Industry or business.....*Snow Hill, Md*

12. Name.....*Henry C. Marshall*

13. Birthplace.....*Virginia*

14. Maiden name.....*Henrietta Blofom*

15. Birthplace.....*Virginia*

16. Informant.....*Mrs Anna Louise Marshall*

Address.....*Snow Hill, Md*

17. Burial, cremation, or removal.....*Buried* Date thereof.....*Sept. 30/45*
 (month) (day) (year)

Cemetery or crematory.....*Whalecoast*

Location.....*Snow Hill, Md*

18. Funeral director.....*Reame & Dumas*

Address.....*Snow Hill, Md*

19. *9/29/45* Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*September 27* 19*45* at *7:53* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 12 19*45* to *Sept 27* 19*45*

and that I last saw him alive on *Sept 27* 19*45*

Immediate cause of death.....*Cerebral Vascular*

accident

Due to.....*Hypertensive Cardio-*

vascular Renal

Due to.....*disease*

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Robert L. La Mar, MD*

Address.....*Snow Hill* Date signed.....*9/28/45*

RECEIVED
OCT 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County... Worcester

City or town... Berlin, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 25 years

3. (a) FULL NAME

alfred M. Moore

3. (b) Social Security Number

4. Sex

Male

5. Color of face

colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife... Mary Moore

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

63

Years

Months

Days

It less than one day

hrs. min.

1882

8. Birthplace...

Delaware

(Town, county, and state)

10. Usual occupation...

Day laborer

11. Industry or business

Henry Moore

12. Name...

Md.

13. Birthplace

Belle West

Md.

15. Birthplace

Kate Moore

16. Informant...

Berlin, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... Sept. 20, 1945

(month) (day) (year)

Cemetery or crematory...

Long's

Location...

Subynville, Del.

18. Funeral director...

Margaret S. Watson

Address...

Pocomoke City, Md.

19. 9/20

19 45

(Date rec'd by registrar)

Helen L. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Worcester

City or town... Berlin, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 18, 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death...

Chronic Brights

DUE TO...

DUE TO...

DUE TO...

Other conditions... Chr. Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Char R. Law

Address... Berlin, Md. M. D. or other

Date signed 9-19-45

RECEIVED
SEP 25 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH:
 County Worcester
 City or town Andover Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Andover
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charlie Parker

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Caucasian 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Parker
 7. Birth date of deceased (mo., day, yr.) July 7 - 1875 6. (c) If alive, give age 66 years
 8. AGE: Years 70 Month 3 Days 13 If less than one day _____ hrs. _____ min.
 9. Birthplace Snow Hill, Worcester, MD
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Stephen Parker
 13. Birthplace Maryland
 14. Maiden name Married Blake
 15. Birthplace Maryland

16. Informant Mrs. Mary Parker
 Address Andover, MD Rural #1
 17. Rural Date thereof Sept. 23/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Michaels
 Location Andover, MD

18. Funeral director Harmon & Sons
 Address Snow Hill, MD

19. 922 19 45 ReRay Smith
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 19 45, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 45, to Sept 18 19 45, and that I last saw him alive on Sept 18 19 45.

Immediate cause of death Coronary Thrombosis of Pabera
 DURATION 6 weeks

Due to _____
 Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None
 Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lo Radinovich MD

M. D. or other

Address Andover, MD Date signed 9/21/45

MASSACHUSETTS DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

RECEIVED
SEP 26 1968
BOARD A.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

09428

Reg. Dist. No. 355

I. PLACE OF DEATH:

County Worcester

City or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carol Wesley Sumrell

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife _____

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1941

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Berlin Md R.F.D.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name William D. Sumrell

13. Birthplace Maryland

MOTHER 14. Maiden name Effie Sumrell

15. Birthplace Maryland

16. Informant William D. Sumrell

Address Berlin Md R.F.D.

17. Burial Date thereof 9/8/41
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Burial: Penn

Location Berlin Md R.F.D.

18. Funeral director Dana A. Burroughs

Address Berlin Md

19. 9-8 45 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1941 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not see body 1941

and that I last saw him alive on Sept. 7 1941

Immediate cause of death _____ DURATION

Premature baby -
About seven months -

Due to _____

Due to Date 7 check reported by
County Health Officer

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE At Johnson M.D. Deputy State Health Officer

M. D. or other

Address Primer Anne, Md Date signed Sept 7, 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 14 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09429

Reg. Dist. No.

355

1. PLACE OF DEATH: Worcester
 County.....
 City or town..... Acron City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:..... no
 How long in hospital or institution?..... no

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Worcester
 City or town..... Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 240 Bay St
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... no

3. (a) FULL NAME..... Wm J. Purcell

3. (b) Social Security Number

Eastland

4. Sex..... male 5. Color or race..... negro 6. (a) Single, married, widowed, or divorced..... married - widower

6. (b) Name of husband or wife..... Margaret Purcell
 yes..... 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Dec 24 about 1872

8. AGE: Years..... 72 Months..... 8 Days..... 13 It less than one day..... hrs. min.

9. Birthplace..... Maryland
 town, county, and state)

10. Usual occupation..... Laborer.

11. Industry or business..... Ice delivery

12. Name..... Charles Purcell

13. Birthplace..... Berlin Md

14. Maiden name..... Gerena Henry

15. Birthplace..... Berlin Md

16. Informant..... Roxie Purcell Jones

Address..... Berlin, Md

17. Burial..... Date thereof..... Sept 12, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Evergreen

Location..... Berlin Md

18. Funeral director..... James H. Stewart

Address..... Baltimore Md

19. 9-12..... 45 Helen J. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 6 19..... 45 at..... 10.10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Myocardial degeneration of heart DURATION..... unknown

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... John L. Ricey Dep. Med Exam M. D. or other
 Address..... Queen Anne St Date signed..... 9/6/45

RECEIVED

SEP 15 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-20

CERTIFICATE OF DEATH

09430

Reg. Dist. No. 357

1. PLACE OF DEATH:

County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Stansbury L. Ritchie

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Josephine O. Ritchie7. Birth date of deceased (mo., day, yr.) June 15 - 1858 8. (c) If alive, give age _____ years8. AGE: Years 87 Months 3 Day 6 If less than one day _____ hrs. _____ min.9. Birthplace: Salisbury, Wicomico, Md. (Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name George W. Ritchie13. Birthplace Maryland14. Maiden name Mary B. Ritchie15. Birthplace Maryland18. Informant Mrs. Sadie R. MumfordAddress Shaptons, Md.17. Burial Date thereof Sept. 23/45 (month) (day) (year)Cemetery or crematorium BatesLocation Snow Hill, Md.18. Funeral director Leanne A. DismickAddress Snow Hill, Md.19. 9/22/45 19. 45 LeRoy Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 19. 45 at 9:30 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 19. 45 to Sept 21 19. 45 and that I last saw him alive on Sept 17 19. 45Immediate cause of death Acute pulmonary edema DURATION 1 dayDue to congestive heart failure & senility 2 mos

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert L. La Mar, M.D. M. D. or other _____Address Snow Hill Date signed 8-22-45

RECEIVED
SEP 26 1944
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH



Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town RURAL, Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 57 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town RURAL, Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Leah White

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Eben White
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Mo & da Unknown 1888
 8. AGE: Years 57 Months ? Days ? It less than one day _____ hrs. _____ min.
 9. Birthplace RURAL, Pocomoke-Worcester-Md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business

12. Name Smith Bacon
 13. Birthplace RURAL Pocomoke City, Md.
 14. Maiden name Hattie Teagle
 15. Birthplace RURAL, Pocomoke City, Md.
 16. Informant Sarah Matthews
 Address Pocomoke City, Md. RFD #2
 17. Burial Date thereof Sept. 11, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. James Cemetery
 Location Pocomoke City, Md. RFD # 2
 18. Funeral director H. Harvey Bradshaw
 Address Pocomoke City, Md.

19. Sept. 11, 1945 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1945 at 12:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/7/45 to 9/7/45
 and that I last saw him alive on 9/7/45
 Immediate cause of death Pulmonary tuberculosis
 DURATION 6 mo.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Cohen M.D.
 Address Brown Hill Date signed 9/18/45
 M. D. or other _____

RECEIVED
SEP 14 1945
BUREAU V.S.